STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HOUSE	2770 S ADAMS RD BLOOMINGTON, IN47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 02/21/11. Survey Date: 05/09/11 Facility Number: 004016 Provider Number: 004016 Aim Number: NA Survey Team: Sharon Whiteman RN TC Marla Potts RN Melinda Lewis RN Census by Bed Type: Residential: 34 Total: 34 Census by Payor Source: Other: 34 Total: 34 Sample: 04 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 5-10-11 Cathy Emswiller RN	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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R0006	(f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to ensure there was no need to discharge a cognitively impaired resident who was potentially dangerous to himself and other residents in that this resident remained in the facility after the following dangerous behaviors: continued to smoke unsupervised in his room, burning holes in the rugs and furniture, wandered into the kitchen, wandered into employee break room taking over the counter medications, for 1 of 4 residents reviewed for proper placement in the facility. (Resident #9)	R0006	**R 006 410 IAC 16.2-5-0.5 (f) (1-5) Scope of Residential Care** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident #9 was re-educated to our smoking policy by the Wellness Director. Resident #9 was re-assessed by the Wellness Director utilizing our smoking assessment and was deemed unsafe to smoke without staff supervision. Residence had a plan in place to remove smoking paraphernalia and provide to resident upon request only under staff supervision. Despite interventions resident	06/17/2011

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	Findings include: On 5/9/11 at 11:00 A.M., Resident # 9's room was observed with Housekeeper # 1. The room was observed to have burn holes in the area rugs in the living area, the recliner, and on top of the television. These were ashes observed on the toilet seat in the bathroom. A pipe and rolling papers were observed on the bed side table. In an interview with Housekeeper # 1 at this time she indicated the room had been cleaned last Thursday, and she indicated Resident # 9 did smoke in his room. The clinical record for Resident # 9 indicated was reviewed on 5/9/11 at 10:00 A.M. The record indicated Resident # 9 had diagnoses that included but were not limited to Alzheimer's disease. A Mini Mental Assessment., dated 1/18/11, indicated a score of 21. The form indicated "...25 or less suggestive of impairment..." The Service Plan, dated 3/7/11, indicated "...Orientation/Behavior/Safety- Do you have trouble recalling the day, date, time, or where you are located? (This was marked with an X.). Do you need assistance with management of any of the		was found to be non compliant and was determined to be inappropriate for continued placement at Monroe House. Resident #9 was issued a notice of involuntary discharge on 5/20/2011. Monroe House has notified all appropriate parties and is currently assisting resident #9 with appropriate placement. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Residents who smoke have been re-assessed by the Wellness Director utilizing the smoking assessment and have been found to be appropriate for continued residency at Monroe House. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The staff at Monroe House was re-educated to our policy and procedure regarding smoking safety requirements. Residents identified as smokers will be assessed by the Wellness Director or Designee upon admission and as needed to ensure continued compliance. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	following behaviors? These behaviors could result in a denial or discharge. (This was marked with an X). Needs occasional redirection. Anxiety or agitation requiring staff management? (This was marked with an X). Do you smoke? ALC [Assisted Living Concepts] residences are smoke-free. (This was marked with an X). Notes: Smokes independently..." In an interview with the Wellness Director, on 5/9/11 at 11:30 A.M., she indicated the X on the service plan indicated this was a concern for the resident. The Resident Services Notes, dated 3/7/11 at 6:05 P.M., indicated "Writer went to residents room to take him dessert. Writer knocked on residents door and got no response, writer opened door and witnessed resident sitting on his bed smoking a cigarette. Writer asked resident to extinguish the cigarette and explained that smoking is prohibited in the house. Resident cupped cigarette and walked past writer and down hallway to the courtyard." The Resident Services Notes, dated 3/7/11 (no time), indicated "Resident was see (sic) going into kitchen he went in and took some chips and cheese."		**assurance program will be put into place?** For the next three months the Wellness Director or designee will perform a random weekly review of residents who smoke for a period of 4 weeks and then quarterly thereafter. Finding will be reviewed at the end of the quarter to determine the need for continued monitoring. Findings suggestive of compliance will result in no further routine monitoring.	

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	The Resident Services Notes, dated 3/9/11 at 8:00 P.M., indicated "Writer took resident his snack and residents room was cloudy and smelled like cigarette smoke. Writer reminded resident that he should only be smoking outside and not in his room. Resident told writer that he understood and would not smoke in his apartment." The Resident Services Notes, dated 3/20/11 at 3:00 A.M., indicated "As I was walking past 121 (Not Resident # 9's room), I noticed cigarette smoke smell. I went in as (Resident # 9) had just finished smoking. I asked if he replied "No, I'm in bed." I reminded him that he cannot smoke in his room." The Resident Services Notes, dated 3/23/11 (no time), indicated "Resident was caught smoking in his room again. He has been asked many times not to do this. Hall smells really bad and other resident are complaining." The Resident Services Notes, dated 3/25/11 at 9:55 P.M., indicated "Staff (writer) entered facility through kitchen doors and found resident in kitchen. He was going through cabinets and holding a piece of cake in his hand. Writer asked resident to leave kitchen area and explained that for resident safety the			

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	kitchen was an employee only area as marked on kitchen entrance door. As writer and resident were exiting kitchen, nurse was coming in and also spoke with resident about being in the kitchen." The Resident Services Notes, dated 3/28/11 (no time), indicated "Resident's daughter (name) was in...will PU [pick up] resident Fri 4/1 to visit MD and review lab results, medication list and resident's current condition. Reviewed with daughter the need for MD to be made aware of the recent increase in behaviors so MD may do an evaluation to determine appropriate interventions." The Resident Services Notes, dated 4/12/11 at 1500 (3:00 P.M.), indicated "Resident has been observed 3 x [times] today searching around front desk area-states he needs some cigarettes, then used phone to call family to tell them he needs cigarettes. Reminded resident that he had already called someone. Resident says someone is bringing him some." The Resident Services Notes, dated 4/20/11 at 11:00 A.M., indicated "Spoke with daughter (name) RE: res [resident] smoking in room. Daughter in agreeance (sic) with nursing staff keeping res smoking supplies. Spoke with res res in agreeance (sic) with keeping smoking			

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	materials with staff et [and] voiced understanding of being able to ask staff for cigarette any time he wanted one. res allowed writer and (name) RN to search room for any smoking supplies. Writer only found a pipe et 2 lighters res denied having any other materials." The Resident Services Notes, dated 4/28/11 (no time), indicated "Called sister to come get him to get ciggestes (sic) said sister was coming got off phone walked out front door was ask to come back in refused got mad told me to shut up had to go and get help to get in (sic) back in. Sister called and told us that she wasn't coming to get him. But his (sic) telling everyone she is." The Resident Services Notes, dated 5/2/11 (no time), indicated "Spoke with res about going out of bldg [building]. Explained he can't go out by self and staff would go out with him to look for cigarettes. Res voiced understanding." The Resident Services Notes, dated 5/6/11 2210 (10:10 P.M.), indicated "Resident found to have gone into employee pocket book. Missing money, candy bar and OTC [over the counter] med [medication]. Candy bar and OTC med found in residents room. He had also taken his newly opened pack of cigarettes found in			

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	his room..." The Resident Services Notes, dated 5/7/11 at 9:00 A.M., indicated "CNA found pills in room after this nurse had administered a.m. meds. This nurse attempted to administer a.m. meds again and saw res put them under his tongue. Asked res to swallow med. Reports no difficulty swallowing, no refusal to take med. Said he wanted his meds. Will continue to monitor..." In an interview with the Wellness Director, on 5/9/11 at 11:15 A.M., she indicated the medication Resident # 9 had taken was Mucinex (decongestant medication). She stated the door to the employee break room was supposed to be locked. In an interview with the Wellness Director, on 5/9/11 at 11:50 A.M., she indicated she was not aware of any smoking assessments done by the facility. On 5/9/11 at 11:45 A.M., the Residence Director provided the facility policy and procedure for Smoke Free Policy, dated 1/03. The policy indicated "...If any current resident that is grandfathered and allowed to continue smoking in his/her apartment because of prior contractual arrangements endangers the health or			

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	welfare of themselves or others, they will be immediately prohibited from smoking. The use of the apartment and outside of the Residence for smoking will also be prohibited also if this resident violated any of the above or does not properly dispose of waste..." In an interview with the Residence Director, on 5/9/11 at 12:15 P.M., he indicated Resident # 9 was not grandfathered in to be smoking in his apartment.			

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R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident's care needs were not neglected, in that the resident was not provided adequate supervision to prevent him from smoking in his room and burning holes on his furniture and rugs; failed to provide adequate supervision to prevent the resident from wandering into the kitchen at night; and failed to provide adequate supervision to prevent the resident from wandering into the employee break room and taking money, candy, and over the counter medicine from an employee "pocket book." This finding affected 1 of 4 residents reviewed for provision of necessary care. (Resident #9)	R0052	**R 052** **410 IAC 16.2-5-1.2 (v) (1-6)** **Residents' Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident #9 was re-educated to our smoking policy by the Wellness Director. Resident #9 was re-assessed by the Wellness Director utilizing our smoking assessment and was deemed unsafe to smoke without staff supervision. Residence had a plan in place to remove smoking paraphernalia and provide to resident upon request only under staff supervision. Despite interventions resident was found to be non compliant and was determined to be inappropriate for continued placement at Monroe House.	06/17/2011

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	Findings include: On 5/9/11 at 11:00 A.M., Resident # 9's room was observed with Housekeeper # 1. The room was observed to have burn holes in the area rugs in the living area, the recliner, and on top of the television. These were ashes observed on the toilet seat in the bathroom. A pipe and rolling papers were observed on the bed side table. In an interview with Housekeeper # 1 at this time she indicated the room had been cleaned last Thursday, and she indicated Resident # 9 did smoke in his room. The clinical record for Resident # 9 indicated was reviewed on 5/9/11 at 10:00 A.M. The record indicated Resident # 9 had diagnoses that included but were not limited to Alzheimer's disease. A Mini Mental Assessment., dated 1/18/11, indicated a score of 21. The form indicated "...25 or less suggestive of impairment..." The Service Plan, dated 3/7/11, indicated "...Orientation/Behavior/Safety- Do you have trouble recalling the day, date, time, or where you are located? (This was marked with an X.). Do you need assistance with management of any of the following behaviors? These behaviors		Resident #9 was issued a notice of involuntary discharge on 5/20/2011. Monroe House has notified all appropriate parties and is currently assisting resident #9 with appropriate placement. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Residents who smoke have been re-assessed by the Wellness Director utilizing the smoking assessment and have been found to be appropriate for continued residency at Monroe House. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The staff at Monroe House was re-educated to our policy and procedure regarding smoking safety requirements. Residents identified as smokers will be assessed by the Wellness Director or Designee upon admission and as needed to ensure continued compliance. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** For the next three months the Wellness Director or designee will	

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	could result in a denial or discharge. (This was marked with an X). Needs occasional redirection. Anxiety or agitation requiring staff management? (This was marked with an X). Do you smoke? ALC [Assisted Living Concepts] residences are smoke-free. (This was marked with an X). Notes: Smokes independently..." In an interview with the Wellness Director, on 5/9/11 at 11:30 A.M., she indicated the X on the service plan indicated this was a concern for the resident. The Resident Services Notes, dated 3/7/11 at 6:05 P.M., indicated "Writer went to residents room to take him dessert. Writer knocked on residents door and got no response, writer opened door and witnessed resident sitting on his bed smoking a cigarette. Writer asked resident to extinguish the cigarette and explained that smoking is prohibited in the house. Resident cupped cigarette and walked past writer and down hallway to the courtyard." The Resident Services Notes, dated 3/7/11 (no time), indicated "Resident was see (sic) going into kitchen he went in and took some chips and cheese." The Resident Services Notes, dated 3/9/11		perform a random weekly review of residents who smoke for a period of 4 weeks and then quarterly thereafter. Finding will be reviewed at the end of the quarter to determine the need for continued monitoring. Findings suggestive of compliance will result in no further routine monitoring.	

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	marked on kitchen entrance door. As writer and resident were exiting kitchen, nurse was coming in and also spoke with resident about being in the kitchen." The Resident Services Notes, dated 3/28/11 (no time), indicated "Resident's daughter (name) was in...will PU [pick up] resident Fri 4/1 to visit MD and review lab results, medication list and resident's current condition. Reviewed with daughter the need for MD to be made aware of the recent increase in behaviors so MD may do an evaluation to determine appropriate interventions." The Resident Services Notes, dated 4/12/11 at 1500 (3:00 P.M.), indicated "Resident has been observed 3 x [times] today searching around front desk area-states he needs some cigarettes, then used phone to call family to tell them he needs cigarettes. Reminded resident that he had already called someone. Resident says someone is bringing him some." The Resident Services Notes, dated 4/20/11 at 11:00 A.M., indicated "Spoke with daughter (name) RE: res [resident] smoking in room. Daughter in agreeance (sic) with nursing staff keeping res smoking supplies. Spoke with res res in agreeance (sic) with keeping smoking materials with staff et [and] voiced			

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	understanding of being able to ask staff for cigarette any time he wanted one. res allowed writer and (name) RN to search room for any smoking supplies. Writer only found a pipe et 2 lighters res denied having any other materials." The Resident Services Notes, dated 4/28/11 (no time), indicated "Called sister to come get him to get ciggestes (sic) said sister was coming got off phone walked out front door was ask to come back in refused got mad told me to shut up had to go and get help to get in (sic) back in. Sister called and told us that she wasn't coming to get him. But his (sic) telling everyone she is." The Resident Services Notes, dated 5/2/11 (no time), indicated "Spoke with res about going out of bldg [building]. Explained he can't go out by self and staff would go out with him to look for cigarettes. Res voiced understanding." The Resident Services Notes, dated 5/6/11 2210 (10:10 P.M.), indicated "Resident found to have gone into employee pocket book. Missing money, candy bar and OTC [over the counter] med [medication]. Candy bar and OTC med found in residents room. He had also taken his newly opened pack of cigarettes found in his room..."			

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		A. BUILDING 00 B. WING	05/09/2011

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The Resident Services Notes, dated 5/7/11 at 9:00 A.M., indicated "CNA found pills in room after this nurse had administered a.m. meds. This nurse attempted to administer a.m. meds again and saw res put them under his tongue. Asked res to swallow med. Reports no difficulty swallowing, no refusal to take med. Said he wanted his meds. Will continue to monitor..."

In an interview with the Wellness Director, on 5/9/11 at 11:15 A.M., she indicated the medication Resident # 9 had taken was Mucinex (decongestant medication). She stated the door to the employee break room was supposed to be locked.

In an interview with the Wellness Director, on 5/9/11 at 11:50 A.M., she indicated she was not aware of any smoking assessments done by the facility.

On 5/9/11 at 11:45 A.M., the Residence Director provided the facility policy and procedure for Smoke Free Policy, dated 1/03. The policy indicated "...If any current resident that is grandfathered and allowed to continue smoking in his/her apartment because of prior contractual arrangements endangers the health or welfare of themselves or others, they will

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	be immediately prohibited from smoking. The use of the apartment and outside of the Residence for smoking will also be prohibited also if this resident violated any of the above or does not properly dispose of waste..." In an interview with the Residence Director, on 5/9/11 at 12:15 P.M., he indicated Resident # 9 was not grandfathered in to be smoking in his apartment.			

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R0117	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview the facility failed to ensure CNA's did not assess residents beyond their scope of practices in that a nurse was not called to assess a resident with complaints of pain and swelling in his foot and complaints of pain in his knees following a fall, for 1 of 4 residents reviewed for care. Findings include:	R0117	**R 117** **410 IAC 16.2-5-1.4 (b)** **Personnel** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** The Wellness Director re-assessed resident #1 on 4/27/2011 post fall and found resident to be free from injury or pain. **How the facility will identify other residents having the potential to be affected by the same deficient**	06/17/2011

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	1. Resident #1's clinical record was reviewed on 5/9/11 at 10:00 A.M. Nurse notes indicated the following: "4/10/11 1:57 A.M. Resident called for assistance with complaints of pain in left writer looked at resident foot It was red and Puffy with very little blanching. Writer suggested to resident that he prop foot on pillow for the night and writer would notify nurses at 7 a.m." This entry was signed by a Certified Nursing assistant. No assessment by a licensed nurse concerning the foot was documented in the nurses notes through 4/17/11. "4/25/11 at 3:18 A.M. called on pendant. went to his room and he was found on his knees. He wanted up helped him up. Claimed he was in pain. Covered resident up an checked on his vitals." During interview with the Wellness Director on 5/5/11 at 10:00 A.M. she indicated she had assessed the resident for injury on 4/27/11. She further indicated staff had called her but they had told her his knees were red and had not said he hurt. The Wellness Director provided a Universal Incident/Occurrence Report on 5/5/11 at 10:30 A.M. which indicated the resident "was found on knees holding on to bed. When staff got him up on his knee		**practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The staff at Monroe House was re-educated to our policy and procedure regarding scope of practice, change of condition, and the ALC Decision Tree. A licensed registered nurse is on call 24/7 in effort to provide assistance with triage of resident care needs who exhibit a change of condition. Residents who exhibit a change of condition will be assessed by a licensed nurse and/or a licensed medical professional and documented within the service notes. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** For the next three months the Wellness Director or designee will perform a random weekly review of resident service notes and incident reports to ensure continued compliance with assessments of resident care needs by a licensed medical professional. Findings will be evaluated at the end of the quarter. Findings suggestive of compliance will result in no further	

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	he said they hurt." The form indicated the Wellness Director had been called at 3:36 A.M. and instructed to check on him again later.		routine monitoring.	